A01: Clinical Approach

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Introduction

The clinical approach represents the minimum standard of assessment that paramedics and EMRs/FRs should provide for a patient. Patients in BCEHS care require ongoing assessments of their vital signs every 15 minutes to monitor trends. If this standard cannot be met, or is considered clinically unnecessary, the rationale should be documented. Patients who are unwell or predicted to deteriorate should have their vital signs monitored more frequently.

For the majority of patients, it will be appropriate to establish a personal rapport and to collect a verbal history prior to beginning any physical assessments. This process should not lead to excessive delays in obtaining vital signs. Critically ill or otherwise unwell patients require a more formalized primary survey and systematic approach to information gathering.

Essentials

BCEHS provides patient-centred care. This means that paramedics and EMRs/FRs will provide safe, effective, and compassionate patient-centred care in all interactions by:

- Treating patients, carers, and families with dignity and respect.
- Encouraging and supporting shared decision making by patients, their families, and carers.
- Communicating and sharing information with patients, their families and carers, and other members of their healthcare team.
- Obtaining consent and considering patient wishes and values in all decisions.

Paramedics must ensure that resuscitation equipment for cardiac arrest management is readily available at **every** patient encounter to promote patient safety for events where the patient's clinical condition is not fully known at the time of dispatch, or may differ from the dispatch information. This includes, at a minimum:

- AED or LifePak 15 monitor/defibrillator
- Jump kit with airway management equipment
- Suction device
- Oxygen

Additional Treatment Information

- **First, do no harm.** Paramedics and EMRs/FRs must act, at all times, with due consideration for the safety of patients:
  - Always assess the risk versus benefit of any treatment or procedure.
  - Advocate for the health and safety of all patients.
  - Demonstrate person-centred care by acting in a manner that ensures the patient’s dignity, safety, privacy, confidentiality, and decision-making are maintained.
- **Professionalism, accountability, and responsibility.** Each paramedic’s and EMR's/FR's professional and legal responsibilities are prescribed by:
  - The Emergency Medical Assistants Regulation and the Code of Ethics.
  - BCEHS Clinical Practice Guidelines, Pharmacology, Skills and Procedures.
  - Compliance with BCEHS Policies and Procedures, Practice Updates, and Safety Alerts.
- **Scope of Practice.** Paramedics and EMRs/FRs must treat within their own scope of practice as defined by BCEHS and the EMALB. Paramedics and EMRs/FRs cannot exceed the legal scope of practice for which they hold an EMA license (including Schedules 1 and 2), though their operational scope of practice can be limited or restricted by BCEHS (→ A04: Duty of Care).
- **Scene assessment.** Safety of the paramedic and EMR/FR, patient, and bystanders is of the utmost priority:

- Scene assessment commences as soon as visual contact is made with the scene (CPG A02: Patient Assessment).
- The dynamic risk assessment must be part of every clinical event. BCEHS does not expect paramedics and EMRs/FRs to place themselves at risk of injury during any patient encounter.

- **Infection Prevention and Control (IP&C).** The main goal of infection prevention and control is to prevent the transmission of health-care-associated infections to patients and paramedic practitioners and EMRs/FRs:
  - The modern application of infection control is described as 'routine practices and additional precautions' which must be applied to every patient for every event.
  - Routine practice does not include the use of personal protective equipment (PPE). Paramedics and EMRs/FRs should apply a point of care risk assessment (PCRA) and, if a hazard exists, apply appropriate precautions (e.g., one of the three isolation procedures).
  - The single most effective IPAC procedure to control infections in the workplace and reduce the spread of infections is hand hygiene.
  - Gloves are task specific and meant for single use for change between procedures and patients. Their use does not replace the need for hand hygiene after their removal.
- **Communication.** Early activation of additional resources is essential:
  - Clear, confident, verbal and nonverbal communication is central to a patient's perception of professional care.
  - Communication must take into account the psychosocial needs of patients, family, and carers.
- **Treatment and Referral Decisions.** It is the responsibility of paramedics and EMRs/FRs to:
  - Perform a comprehensive patient assessment (→ A02: Patient Assessment).
  - Discuss and explain the patient's presenting clinical condition, including any related comorbidities, with the patient or their carer and determine the appropriate treatment and referral decisions.
  - Manage the patient as required through the application of the BCEHS Clinical Practice Guidelines.
  - If in doubt about the diagnosis and the specific treatment required, give basic supportive measures, minimize time on scene, and consult with CliniCall (1-833-829-4099) if possible.
- **Conveyance Decisions.** Time on scene must be kept to a minimum with only time critical and/or meaningful interventions performed on scene with additional treatment provided en route:
  - If the arrival time of clinical back-up is expected to exceed the time required to load and convey the patient to a hospital, paramedics and EMRs should convey the patient.
  - In the event that higher levels of care or additional resources are required for safe patient care, en route intercepts can be considered.
- **Choice of Clinical Pathway.** The clinical pathway is influenced by the patient's presenting condition and the relative proximity to a designated specialized care facility. Follow BCEHS clinical pathways when determining hospital destinations:
  - Stroke patients may bypass the local facility and proceed directly to a primary or comprehensive stroke centre as directed by the FAST-VAN Stroke Tool and regional stroke clinical pathways.
  - STEMI patients may bypass the local hospital and proceed directly to a facility with specialty expertise in reperfusion strategies, in accordance with regional patient pathways.
  - Trauma patients may bypass local facilities and be transported directly to a trauma centre. Follow guidelines in the local clinical pathways.
  - Certain patients may meet criteria to be conveyed to alternate destinations where local clinical pathways are available.
- **Alternative referral decisions.** When patients are not conveyed by ambulance, paramedics or EMRs must:
  - Provide the patient with information on how to manage their condition, what to do if their condition does not improve, and when to see their general practitioner.
  - Confirm the patient is able to mobilize, access transport, and attend alternative care facilities.
- **Ambulance off-load.** Prepare patient and equipment for off-loading:
  - Remove PPE prior to leaving the vehicle and perform hand hygiene.
  - If the patient's condition does not allow for the removal of PPE, remove and replace gloves prior to departing the ambulance.
  - On-going patient assessment and treatment continues at the receiving facility until the formal clinical handover takes place including serial vital sign assessments, continuation of various monitoring devices, and rechecking the effectiveness of interventions.
- **Clinical handover.** It is the responsibility of paramedics and EMRs/FRs to ensure they provide and/or receive a comprehensive clinical handover using the mnemonic ATMIST or SBAR (→ A03: Clinical Handover) whenever patient

care responsibility changes from one clinician to another and to ensure they understand all care requirements for the patient:
  - Whenever possible, and when it is in the best interest of the patient, practitioners should provide the handover report with the patient in view of the accepting healthcare provider to facilitate patient recognition and encourage assessment as required.
  - It is recognized that extenuating circumstances may make it unacceptable to complete clinical handover in the presence of the patient.
- **Documentation.** Documentation is important and a clinical record is required for all patient contact (→ A06: Documentation Standards); patient care documentation must:
  - Be accurate, as factual as possible, and provide a clear, concise, and complete account of the event.
  - Be completed at the time of, or as close as practicable to, the event.
  - Incorporate all treatments/interventions provided, including patient vital signs and assessment findings prior to and post treatment, and recording of ECGs where appropriate.
    - Note: In cases where a minimum of two sets of vital signs are not taken or recorded, paramedics and EMRs must document the reasons within the free text in the clinical record.
  - Record the paramedic or EMR recommendations and reasons, including a summary of any communication between the paramedic or EMR and patients and/or carers.
  - Record a copy of any first responder documentation.
  - Record any advice provided by a Paramedic Specialist or the emergency medical services physician online support doctor.
  - Record at least the minimum dataset required per CPG A06: Documentation Standards.
  - Practitioners shall leave copies of the patient care record and any associated documentation with the receiving facility prior to leaving the facility. This may include uploading a digital version of the ePCR without printing a hard copy.
  - When available, ECG's must include the patient name and copies of the pre/post treatment (e.g., SVT treatment with adenosine).
  - Document and co-sign all controlled substance usage and wastage in the patient care record as per BCEHS MP 210.
  - Ensure verbal orders from a physician, direction from a Paramedic Specialist, or communication with CliniCall are documented in the ePCR.
  - Transcribed orders must fall within the scope of practice of the paramedic or EMR.

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. New South Wales Ambulance Service. Protocols & Pharmacology. 2020. [Link]

Practice Updates

- 2023-05-23: added minimum equipment requirement to Essentials